Redcar-Cleveland
Community Safety Partnership

Executive Summary

Domestic Homicide Review

Name: Annie

Died: August 2018

Chair: Paul Cheeseman
Author: Ged McManus
Date: June 2019

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1 The Review Process

1.1 This summary outlines the process undertaken by the Redcar-Cleveland Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Annie, who was a resident in their area.

1.2 The following pseudonyms have been in used in this review for the victim and perpetrator in order to protect their identities.

Name	Who	Age	Ethnicity
Annie	Victim	66	White British
Simon	Perpetrator	61	White British

1.3 Following an evening spent together at Annie's house in August 2018, Simon murdered her before leaving the house and going to tell his daughter what he had done. He was heavily intoxicated. He then returned to his own home and was found to have self-harmed when police officers forced entry in order to arrest him.

1.4 Following Annie's death, a referral was made to the Redcar-Cleveland Community Safety Partnership by Cleveland police. A Scoping Meeting took place on 12 September 2018, where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed on 7 November 2018. A trial date was set for Simon in February 2019. In the meantime, work commenced on gathering the information needed for the review. Simon pleaded guilty before the case went to trial and the DHR panel was then able to progress its work.

1.5 The review began on 22 November 2018 and the panel met on four occasions. The review was concluded on 14 June 2019, following consultation with Annie's family.

2 Contributors to the review

Agency	Contribution
Cleveland Police	IMR
South Tees Clinical Commissioning Group	IMR
Tees Esk and Wear Valleys NHS Foundation Trust	Short report
National Probation Service	Chronology of historic involvement

3 Members of the Domestic Homicide Review Panel

3.1	Paul Cheeseman	Independent Chair
	Ged McManus	Support to chair and author
	Annie Potter	Head of quality and adult safeguarding, South Tees Clinical Commissioning Group
	Karen Agar	Associate Director of nursing [safeguarding] Tees Esk and Wear Valleys NHS Foundation Trust
	Darren Birkett	Detective Inspector Cleveland Police
	Rachel Hodge	Probation officer, National Probation Service
	Jay Hosie	Redcar-Cleveland Community safety Partnership
	Richinda Taylor	CEO EVA Women's Aid

Mandy Cockfield	Service manager Redcar-Cleveland Adult Social Care
Leanne Best	Domestic Abuse coordinator Redcar-Cleveland council
Gary Besterfield	Service manager Addaction
Joanne Walker	Support to panel

3.2 The review chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

4 Chair and author of the overview report

4.1 Paul Cheeseman was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He was judged to have the skills and experience for the role. He was assisted by Ged McManus who wrote the report. He is currently Independent Chair of a Safeguarding Adult Board in the north of England and has chaired and written previous DHRs and Safeguarding Adult Reviews. Both practitioners served for over thirty years in different police services in England. Neither of them has previously worked for any agency involved in this review. Ged McManus has chaired and written one previous DHR in Redcar-Cleveland.

5 Terms of Reference

5.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

5.2 **Timeframe under Review**

The DHR covers the period 1 October 2017 to the homicide of Annie in August 2018.

5.3 **Subjects of the DHR**

Victim: Annie aged 66 years

Perpetrator: Simon aged 61 years

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Annie as a victim of domestic abuse and what was your response?

2. What risk assessments did your agency undertake for Annie; what was the outcome and if you provided services were they fit for purpose?

3. What was your agency's knowledge of any barriers faced by Annie that might have prevented her reporting domestic abuse and what did it do to overcome them?

4. What knowledge did your agency have of any alcohol, drug, gambling, addictions or mental health issues in respect of Simon and/or Annie? What services did your agency provide in response to these issues?

5. What knowledge or concerns did the victim's family and friends have about Annie's victimisation and did they know what to do with it?

6. What knowledge did your agency have that indicated that Simon might be a perpetrator of domestic abuse and what was the response? Did your agency consider making a referral to a Multi-Agency Risk Assessment Conference [MARAC], Multi-Agency Public Protection Arrangements [MAPPA] or any other programme intended for the management of individuals considered to be prolific or that presented a high risk of harm to others?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Annie and Simon?

8. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

9. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Annie and Simon, or on your agency's ability to work effectively with other agencies?

10. What learning has emerged for your agency?

11. Are there any examples of outstanding or innovative practice arising from this case?

12. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Redcar - Cleveland Community Safety Partnership?

6 Summary chronology

6.1.1 Simon had a history of violence before he met Annie. Between 1992 and 1996 he was convicted of assault, false imprisonment and manslaughter. All of the victims were women and the victim of manslaughter was Simon's partner who he lived with at the time.

6.1.2 The circumstances of the death of Simon's partner in 1996 bear a striking similarity to Annie's death. Both Simon and his partner misused alcohol and he strangled her to death following an argument. Simon was sentenced to three years imprisonment and due to the time that he had spent remanded in custody before the trial, served only a year in custody before his release.

6.1.3 It is believed that Annie and Simon met in Redcar in 2009. Both of them were chronic alcoholics.

6.1.4 Simon did not come to the attention of the police again until 2011 when, following a domestic abuse incident, Annie called the police to report that Simon had assaulted her. She later chose not to make a statement or support a prosecution and therefore no action was taken against Simon.

6.1.5 In 2012, Simon sought help to reduce his alcohol intake and within three months reported a significant reduction in alcohol consumption. He was discharged from the service and there is no record of him seeking further help.

6.1.6 Simon came to the attention of the police on three other occasions, when three different women contacted them.

- 2013, a female neighbour reported to the police that Simon had assaulted her. The case was withdrawn when the victim withdrew her evidence.
- 2016, a female who had been in a relationship with Simon for three months reported that she was feeling suicidal. Police arranged appropriate medical treatment.
- 2018, a female reported to police that Simon had sexually assaulted her at a party. The report could not be substantiated.

6.1.7 Annie also contacted the police in October 2017 when she alleged that Simon had stolen her house key, she later rang back to say that she had found the key. Despite this police officers attended and treated the call as domestic abuse, but Annie chose not to complete the DASH risk assessment or seek any support.

6.1.8 Both Annie and Simon's alcohol misuse was known to their GP's, but it appears that at least in recent times they did not want support to reduce their alcohol intake. Annie said her alcohol consumption was within normal limits. Simon said that he was drinking 210 units per week but declined any support.

6.1.9 In the twenty-six years, between 1992 and Annie's death in 2018, Simon was involved in incidents of violence, domestic abuse or sexual assault involving seven different women. What in hindsight can be seen as a pattern of drink fuelled abuse, was not apparent to the police or any other agency. The relatively long periods between reports of Simon's poor behaviour meant that

each incident was treated in isolation despite the fact that he had a conviction for killing his partner.

6.2 Key events

6.2.1 Prior to the terms of reference

6.2.2 On 6 February 1992, Simon appeared at court and was fined for assault causing actual bodily harm.

6.2.3 On 22 October 1993, Simon appeared at court and was sentenced to two years imprisonment for threats to kill his then female partner.

6.2.4 On 13 May 1996, Simon was sentenced to three years imprisonment for the offence of manslaughter. This was in relation to the death of his female partner who he had lived with since his last release from prison.

It was said in court that there was a stormy relationship between them, the victim was three times over the legal alcohol limit for driving and was strangled during a drink related argument over an alleged affair. Post mortem showed that the victim suffered with an undiagnosed and serious cardiac disease and could have died at any time. The slightest squeeze to throat would have resulted in instant death. The basis of the guilty plea was a lack of intent to cause serious harm. There was no evidence of a struggle.

Simon also had a history of personal problems during recent years; he experienced the death of a paraplegic child; his marriage with his childhood sweetheart ended; he consumed excessive amounts of alcohol whilst working in licenced premises. The victim's daughter talked of her mother's relationship with Simon initially having a very calming effect on him.

The sentencing judge's comments were recorded as follows

"you killed [your partner] by strangling; her. Your plea is accepted on the basis that you didn't intend to harm or even kill her. Guilty plea, some indication of remorse and some evidence that you contemplated suicide. I recognise some of the recent tragic events in your life, both of you had a lot to drink. This is an exceptional case in many respects as outlined in pathological reports and I accept that death was instantaneous when you squeezed her neck. Not the normal manslaughter/provocation case, difficult sentencing exercise - however you behaved in an unlawful & dangerous manner by putting your hands around her throat. There has to be a price".

6.2.5 On 22 May 2011, Annie rang the Police to say that Simon had assaulted her. Simon was arrested and interviewed but released with no further action as Annie did not wish to provide a statement nor support a prosecution.
Annie answered yes to 9 of the 27 DASH[1] questions and the incident was graded as medium risk by the attending officer and supervisor. Comment was added to the DASH form around Simon's previous domestic related manslaughter conviction in 1995. A referral to domestic abuse services was made. The police made a follow up call to Annie and sent a standard letter which contained support and advice and useful telephone numbers. From the material that is available it does not appear that Annie sought any further support from services following the receipt of this letter.

6.2.6 On 1 May 2012, Simon self-referred to a drugs and alcohol treatment open access clinic. He disclosed a long history of alcohol misuse and his previous convictions. He requested help to reduce his alcohol intake. He claimed that his alcohol use was to blame for his violent past and as a result he tended to isolate himself when he could during drinking episodes as he was worried he may get into conflict with others. He said that during violent episodes he had no empathy for those involved and any harm to others was intentional. The notes from that disclosure do not reveal the names of the person[s] he was referring to in respect of that remark.

6.2.7 On 8 August 2012, Simon attended the drugs and alcohol clinic appointment. He reported a significant reduction in alcohol consumption and was discharged from the service with information on how to seek further help if required.

6.2.8 On 27 July 2013, a female neighbour reported that Simon had punched her and pulled her hair. He was arrested and charged with assault, but the case was withdrawn at court when the victim chose not to provide evidence.

[1] The Domestic Abuse, Stalking and Honour Based Violence [DASH 2009] Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council [NPCC]

6.2.9 In 2016, Simon told his GP that he was consuming 210 units per week[2] but did not want any interventions. The GP did not document what advice was given or if a referral was made.

6.2.10 On 20 December 2016, police were contacted by a female [not Annie] who stated she was feeling suicidal after an argument with Simon. She said that she had been in a relationship with Simon for around three months and they were both alcoholics. Appropriate medical treatment was sought for her.

6.2.11 **Within the dates of the Terms of Reference**

6.2.12 On 13 October 2017, Annie attended a GP appointment following a number of letters encouraging her to do so. She had her blood pressure checked and the doctor discussed her alcohol consumption. Annie told the doctor that her consumption of alcohol had reduced and was within normal limits.

6.2.14 On 29 October 2017, Annie telephoned the police and reported that Simon had taken her house keys. She said, "he was a horrible person and was always trying to take her stuff". Annie was intoxicated at the time of this call which was made at 09:33. Annie rang the police control room back at 11:54 to say that she had found the keys and everything was ok. As it was a domestic incident, an officer attempted to see Annie in person on 29 October and again on 30 October but there was no answer at the door or to telephone calls. Police officers did eventually see her on 31 October. The officer attempted to complete the DASH questions with Annie, but she chose not to provide answers and insisted she did not require any support, that there were no issues and she did not wish to provide consent to share information with other agencies. The officer raised the issue of alcohol consumption with Annie as she was intoxicated at 0930 when making the call and Annie said she was an alcoholic but was reducing her intake.

The incident was classed as standard risk by the attending officer and supervisor with no crime recorded and because of this standard grading with no consent to share information, no referrals were made to support agencies. Annie could not remember the previous call she made to police in 2011 without prompting and she stated that Simon had never been violent towards her previously. She stated they had agreed to separate after this incident.

[2] The Chief Medical Officers' guideline for both men and women is that: You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.

6.2.15 On 17 March 2018, a female reported that Simon had sexually assaulted her by putting his hand between her legs whilst they were drinking with a group of people in a third parties' home. Other people present said that they did not see anything or chose not to make a statement. Hence, although Simon was arrested there was insufficient evidence to support a charge.

7 Key issues arising from the review

1. Annie and Simon were both chronic alcoholics.
2. The couple did not readily engage with 'authority' and were little known to agencies in Redcar-Cleveland.
3. Simon was a serial abuser who abused at least seven women including Annie over a period of twenty six years.
4. Only two domestic abuse incidents were reported to the police during their nine year relationship.
5. The couple appeared not to want support to reduce their alcohol intake.

8 Conclusions

8.1 Annie and Simon had been in a relationship for nine years. It is thought that they met whilst living in the same block of bed sits. With the help of her family Annie moved out and lived in a small rented house in Redcar. Simon maintained the tenancy of his bed sit but often stayed with Annie.

8.2 During the course of their relationship Annie called the police on two occasions. In 2011, she reported that Simon had assaulted her but chose not to make a statement and no action was taken. In 2017, she reported that Simon had stolen her door key but withdrew the allegation saying she had found the key. The two isolated incidents were dealt with correctly and neither of them highlight that Annie was at high risk of harm from Simon.

8.3 The couple both misused alcohol for many years. Despite this they were not reliant on local statutory or voluntary services and lived an independent life, largely under the radar of local services. Simon sought help to control his alcohol consumption on one occasion in 2012, but otherwise declined help. Annie minimised the extent of her alcohol consumption when asked about it.

8.4 Annie's family knew of the relationship between the couple and met Simon. They were unaware of any issue of domestic abuse between the couple although the, sometimes sporadic, nature of contact with Annie meant that

they had times when they did not see her. In hindsight the family wonder if this lack of contact may have been due to pressure from Simon.

8.5 Simon misused alcohol and was abusive to women. The full list of his known potentially abusive behaviour is shown below.

- 1992 assault.
- 1993 false imprisonment and threats to kill.
- 1996 manslaughter.
- 2011 assault on Annie.
- 2016 female who was in a relationship with Simon reported feeling suicidal following an argument.
- 2013 punched a female neighbour and pulled her hair.
- 2017 allegation of theft of door key [recanted by Annie].
- 2018 female reported that Simon had sexually assaulted her.

8.6 No allegation after the 1996 manslaughter conviction led to a conviction and the relatively long periods between reports of Simon's poor behaviour meant that each incident was treated in isolation, despite the fact that he had a conviction for killing his partner. Although the records are no longer available it is known that Simon was sentenced to three years imprisonment, he then spent nine months on licence supervised by the predecessor organisation to National Probation Service after his release from prison. This was followed by nine months on 'at risk' licence which means that he would not have had to attend appointments but had he committed any further offences then he would have been liable for recall to custody. As the conviction was for manslaughter then there was no requirement for further probation involvement and Simon was not engaged in any way with the National Probation Service.

8.7 Annie's family believe that she was unaware of the seriousness of Simon's previous offending, as were they. Had they been aware they would have tried to talk to her and dissuade her from the relationship.

9 Learning identified

9.1 Narrative

Annie and Simon were chronic alcoholics who continued to function and did not readily seek assistance from services. Annie's family were aware of her problems but did not know how to seek help or encourage her to do so.

Learning

There is a need to publicise local services and empower individuals and their families to seek appropriate help and support.

9.2 Narrative

Simon had a history of violence towards women including killing a previous partner. Despite that, his violence towards Annie and other women did not meet the threshold for any further intervention or multi agency management.

Learning

The seriousness of previous offending should be a factor in professional judgement of when to make a MARAC referral. This is particularly the case where a person has caused a death previously.

9.3 Narrative

Both Annie and Simon were chronic alcoholics who did not readily engage with services, minimised their issues and declined support.

Learning

People who do not easily engage with services can be supported to do so. Professionals need to be fully aware of the available services in their area.

10 Panel Recommendations

10.1 Redcar-Cleveland Community Safety Partnership should work with partners to ensure that local alcohol services are accessible and easily understood to potential service users and their families. For example, an internet search has found that local alcohol services are almost impossible to understand. Some

results bring up previous provider CGL. Those that bring up Addaction then provide links to Blackpool and Hartlepool.

10.2 Redcar-Cleveland Community Safety Partnership and Cleveland police should ensure that professionals use their professional judgement to consider the seriousness of previous offending as a factor in making MARAC referrals. In cases where a person is responsible for a previous death a MARAC referral should always be considered.

10.3 Redcar-Cleveland Community Safety Partnership should seek assurance that professionals in Redcar-Cleveland are fully aware of the Transformation Challenge Key worker team and how referrals can be made.

10.6 **Single agency recommendations**

There are no single agency recommendations as a result of this review.

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Community safety Partnership	Redcar-Cleveland Community Safety Partnership
Local DHR Reference	DHR2
Police Force	Cleveland Police
Date first notified to Home Office	7 November 2018
Name of review panel chair	Paul Cheeseman
Name of report author	Ged McManus
Date report completed	14 June 2019
Date submitted to Home Office	

	Victim
Gender	Female
Age at time of incident	66
Relationship to perpetrator	Partner
Ethnicity	White British
Nationality	British
Religion	Christian
Sexual orientation	Hetrosexual
Disability	no

	Perpetrator
Gender	Male
Age at time of incident	61
Relationship to victim	Partner
Ethnicity	White British
Nationality	British
Religion	Christian
Sexual orientation	Hetrosexual
Details of verdict	Not applicable

	General
Date of homicide	15 August 2018
Place of murder	Redcar
Method of killing	Strangulation
Number of children in household	0

Appendix A

Community Safety Partnership							
No	**Recommendation**	**Scope ie Local/national**	**Action to take**	**Lead Agency**	**Key Milestones Achieved in enacting Recommendation**	**Target Date**	**Date of Completion & Outcome**
1	Redcar-Cleveland Community Safety Partnership should work with partners to ensure that local alcohol services are accessible and easily understood to potential service users and their families. For example, an internet search has found that local alcohol services are almost impossible to understand. Some results bring up previous provider CGL. Those that bring up Addaction then provide links to Blackpool and Hartlepool.	Local					
2	Redcar-Cleveland Community Safety Partnership and Cleveland police should ensure that professionals use their professional judgement to consider the seriousness of previous offending as a factor in making MARAC referrals. In cases where a person is responsible for a previous death a MARAC referral should always be considered.	Local					

3	Redcar-Cleveland Community Safety Partnership should seek assurance that professionals in Redcar-Cleveland are fully aware of the Transformation Challenge Project or subsequent service offer, and how referrals can be made.	Local					